TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GENEVA MEDICAL MANAGEMENT, INC

Respondent Name
FRANK WINSTON CRUM INSURANCE

MFDR Tracking Number
M4-16-3793-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
AUGUST 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 99456 with the component modifier -26. Reimbursement for the examining doctor is 80% of the MAR. The physical therapist and/or health care provider other than the examining doctor that performs the…testing…is 20% of the MAR…Total Reimbursement is $650.00."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16, 2016	CPT Code 99456-W5-26 and 99456-W5-TC Designated Doctor Evaluation	$300.00	$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.

The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on August 29, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's

dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

Is the requestor entitled to additional reimbursement?

Findings

1. On the disputed date of service the requestor billed CPT code 99456-W5-26 and 99456-W5-TC.

- 28 Texas Administrative Code §134.204(i)(1)(A) states "The following shall apply to Designated Doctor Examinations. (1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor"

A review of the submitted medical billing finds that the requestor billed modifier "W5" as the first modifier appended to CPT code 99456.

- 28 Texas Administrative Code §134.204(j)(3) states "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350."

The requestor billed CPT code 99456 because the examination was performed by a designated doctor.

- Per 28 Texas Administrative Code §134.204(j)(4)(C)(iv) states "If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR.

The requestor appended modifier 26 to code 99456 because the professional component of the examination was performed by Rory Allen, DO.

- Per 28 Texas Administrative Code §134.204(j)(4)(C)iv) states "If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR."

The requestor appended modifier TC to code 99456 because a certified technician performed the testing.

The Division finds that the Designated Doctor billed for the evaluation/examination in accordance with 28 Texas Administrative Code §134.204; therefore, reimbursement is recommended.

2. The maximum allowable reimbursement (MAR) for CPT code 99456-W5-26 and 99456-W5-27 is:

- 28 Texas Administrative Code §134.204(j)(1) states "Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:
  (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR.
- 28 Texas Administrative Code §134.204(j)(4)(C) states "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas."
- 28 Texas Administrative Code §134.204(j)(4)(C)(ii) states "The MAR for musculoskeletal body areas shall be as follows.
  (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
  (II) If full physical evaluation, with range of motion, is performed:

(-a-) $300 for the first musculoskeletal body area; and
(-b-) $150 for each additional musculoskeletal body area."

The requestor billed for MMI/IR of one body areas. A review of the Designated Doctor report finds that a full evaluation with range of motion was performed on the left thumb and index finger; therefore, the MAR is $300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a).

Per 28 Texas Administrative Code §134.204(j)(3)(C) the requestor is due $350.00 for the MMI evaluation.

The Division finds that the total allowable for the MMI/IR evaluation is $650.00. The respondent paid $350.00. As a result, the requestor is entitled to reimbursement of $300.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Elizabeth Pickle, RHIA	12/14/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.